Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
518-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

RON HOXWORTH MD
1801 INWOOD ROAD
DALLAS TX 75390-9132

Respondent Name

TRAVELERS CASUALTY INS CO

Carrier's Austin Representative Box

Box Number 05

MFDR Tracking Number

M4-12-1200-01

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "A copy of the 1st and 2nd level appeal requests that were sent to Travelers Insurance Company is attached for review. The carrier has maintained the original processing of our claim; we are therefore requesting this claim to be reviewed by your agency."

Amount in Dispute: $554.29

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The Carrier maintains the Provider is not entitled to separate reimbursement for the joint manipulation. The Medicare CCI edits dictate the reimbursement for the joint manipulation is included in the reimbursement for the muscle debridement, CPT code 11044. The Provider alleges the use of the -59 modifier to CPT code 26340 indicates a separate and distinct procedure which is entitled to separate reimbursement. The explanation for the use of the -59 modifier included in the CPT codebook clearly indicates the -59 modifier should be used to indicate a separate and distinct procedure, marked by a separate incision or procedure sight. As documented by the operative report included in the Provider's Request for Medical Fee Dispute Resolution, this was clearly not a separate incision or surgical sight. The joint manipulation was performed to confirm the tendon had been fully released, was performed while the single incision was still open, and was integral to the primary procedure of freeing the tendon contracture."

Response Submitted by: Travelers, 1501 S Mopac Expressway, Ste. A-3230, Austin, TX 78746

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
May 24, 2011	CPT Code 26340	$554.29	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.

Issues

1. Did the requestor submit the request for medical fee dispute resolution in accordance with 28 Texas Administrative Code §133.307 and is the requestor entitled to reimbursement?

Findings

1. Per 28 Texas Administrative Code §133.307(c)(2)(A), the provider shall complete the required sections of the request in the form and manner prescribed by the Division. The provider shall file the request with the MDR Section by any mail service or personal delivery. The request shall include: (A) a copy of all medical bill(s), in a paper billing format using an appropriate DWC approved paper billing format, as originally submitted to the carrier a copy of all medical bill(s) submitted to the carrier for reconsideration in accordance with §133.250 of this chapter (relating to Reconsideration for Payment of Medical Bills). Review of the documentation shows that bills were not submitted by either party; the Division cannot confirm what CPT Codes were billed and if a correct modifier was appended. The Division concludes that the requestor has not met the requirements of §133.307(c)(2)(A); therefore, reimbursement cannot be recommended.

Conclusion

The Division concludes that this dispute was not filed in the form and manner prescribed under Division rules at 28 Texas Administrative Code §133.307. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	May 24, 2012 Date

YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.